SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
Company Tracking Number:	*GCI50014-AR-0808*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.002A Dread Disease - Cancer Only*
Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Filing at a Glance

Company: AIG Life Insurance Company

Product Name: Group Critical Illness / Cancer	SERFF Tr Num: AMGN-125783910	State: ArkansasLH
TOI: H07G Group Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 40007
Sub-TOI: H07G.002A Dread Disease - Cancer Only	Co Tr Num: GCI50014-AR-0808	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Maggie Sheehan	Disposition Date: 08/24/2008
	Date Submitted: 08/20/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Application for Group Livestrong Cancer Insurance Plan	Status of Filing in Domicile: Authorized
Project Number: GCI50014-AR-0808	Date Approved in Domicile: 04/04/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: Resubmission	Previous Filing Number: AMGN-125549695
Group Market Size: Small and Large	Overall Rate Impact:
Group Market Type: Employer, Association	Filing Status Changed: 08/24/2008
	State Status Changed: 08/24/2008
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

AIG Life Insurance Company wishes to submit the above referenced filing for your review and approval. This application replaces the individual application GCI50014-AR-0208, which was previously filed and approved by your Department on March 18, 2008. This application will be used with the Group Critical Illness Insurance product previously approved by your Department.

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
Company Tracking Number:	*GCI50014-AR-0808*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.002A Dread Disease - Cancer Only*
Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Our underwriting and marketing department has decided to make a few changes to the previously approved application (GCI50014-AR-0208). We have added a disclaimer just prior to the health questions, this disclaimer will be included as shown or omitted depending on plan design. Also, we have bracketed the title of the ACKNOWLEDGEMENT-AGREEMENT-AUTHORIZE-UNDERSTAND section, and the entire Authorize provision. We would like the flexibility to change the title to remove the word “Authorize” and will remove the entire Authorize section for certain plan designs with the understanding that if removed AIG will not be authorized to obtain the referenced reports.

Lastly, our underwriting department has decided on a more liberal underwriting approach with respect to the health questions and therefore has decided to have 2 versions of question #2 and we will use the version that is best matched up with plan design and marketing method. Question 2 – either the option 1 or option 2 question will be used depending on plan design and marketing method. Only one of these options will be used at a time. The look back period may range from 12 – 36 months but will never exceed the amount allowed by the state.

There are no other changes from the previously approved form.

Any bracketed information is being filed as variable and is illustrative. An Explanation of Variability (EOV) is included. Unless otherwise informed, we reserve the right on a case by case basis to alter the layout of the enclosed form, including color, type face and font, and to go outside the range of variables set forth in the application if we are requested to do so by the policyholder, but will only do so if such changes are within the allowable parameters or requirements in the state statutes.

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed. For example, the logo at the top of the application will be the logo of the association or company utilizing the application, who will then determine the address of the administrative office.

The flesch score for this form is enclosed.

To comply with the retaliatory fee requirement, included is a check in the amount of $50.00.

This application will be implemented for use upon approval by your Department.

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
Company Tracking Number:	*GCI50014-AR-0808*		
TOI:	*H07G Group Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07G.002A Dread Disease - Cancer Only*
Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Your review of this filing is appreciated. Please contact me if you have any questions.

Sincerely,
Maggie Sheehan
Analyst, Product Management
Maggie_sheehan@aigag.com
(732) 922-768; (800) 548-4672
FAX: (732) 922-5593

Company and Contact

Filing Contact Information

Maggie Sheehan, Analyst
3600 Route 66
Neptune, NJ 07754

maggie_sheehan@aigag.com
(732) 922-7688 [Phone]
(732) 922-5593[FAX]

Filing Company Information

AIG Life Insurance Company
600 King Street
Wilmington, DE 19801
(713) 831-3508 ext. [Phone]

CoCode: 66842
Group Code: 12
Group Name:
FEIN Number: 25-1118523

State of Domicile: Delaware
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
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Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AIG Life Insurance Company	$50.00	08/20/2008	22032806

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
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Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/24/2008	08/24/2008

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
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Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Disposition

Disposition Date: 08/24/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	NAic Transmittal	Approved-Closed	Yes
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Form	Application for Group Livestrong Cancer Insurance Plan	Approved-Closed	Yes

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
Filing Company:	*AIG Life Insurance Company*	*State Tracking Number:*	*40007*
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Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Form Schedule

Lead Form Number: GCI50014-AR-0808

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GCI50014-AR-0808	Application/ Enrollment Form	Application for Group Livestrong Cancer Insurance Plan	Revised	Replaced Form #: GCI50014-AR-0208 Previous Filing #: AMGN-125549695	46	AR Final Livestrong APP 8-08.pdf

[AIG AMERICAN GENERAL] [Association/Entity Logo] [**Instructions**]

APPLICATION FOR GROUP [LIVE**STRONG**™ CANCER INSURANCE PLAN] [LIVE**STRONG**™ CANCER PLAN] [LIVE**STRONG**™ CANCER INSURANCE] [LIVE**STRONG**™ CANCER RECOVERY PLAN]

Underwritten by [AIG Life Insurance Company]
(Herein called the Company)
A member company of American International Group, Inc.
[Administrative Office: 3600 Route 66, Medical Underwriting 3-L, P.O. Box 1588 Neptune, NJ 07754-1588]

[Sponsoring Association Name]

[Member/Applicant] Name:
_____]
First Middle Last

[Address: _____
Street
_____]
City State Zip

Please provide the following personal information:

[Sex: Male: ☐ Female: ☐]
[Date of Birth_____]
[Social Security No: _____]
[Phone No: (___)_____]
[E-mail address:_____]

[The below section *only* to be completed by Preferred Plan Applicants. *Members applying for the Basic Plan do NOT need to answer these questions. The Basic Plan is offered on a guaranteed-issue basis. The Preferred Plan is offered on a simplified-issue basis and requires that you answer two health questions. Your approval for coverage will be based on your answers. If you do not qualify for the Preferred Plan, you will not be able to enroll in the guaranteed-issue Basic Plan.*]

[Please answer these brief questions.

[Member] [Spouse]

[1.] In the past [10 years] has any Proposed Insured been diagnosed with or received treatment or advice from a Medical Professional for cancer (including skin cancer and melanoma), leukemia, Hodgkin's disease, lymphoma, pre-malignant lesions or any immune deficiency disorder? ☐ Yes ☐ No ☐ Yes ☐ No

[2. Option 1] Within the past [12 months] has any Proposed Insured been advised by a Medical Professional to have any examinations, surgery or other medical tests to confirm, exclude or screen for the presence of cancer, or had test results which were abnormal or still pending? ☐ Yes ☐ No ☐ Yes ☐ No

[2. Option 2] Within the past [12 months] has any Proposed Insured had any abnormal test results for cancer? ☐ Yes ☐ No ☐ Yes ☐ No]

[I attest that no proposed insureds have been diagnosed or treated by any member of the medical profession for cancer (including skin cancer and melanoma), leukemia, Hodgkin's disease, lymphoma, pre-malignant lesions or any immune deficiency disorder, nor have any proposed insureds been advised by a Medical Professional to have any examinations, surgery or other medical tests to confirm, exclude or screen for the presence of cancer, or had test results which were abnormal or still pending.

_____
Signature of Primary Applicant]

[1.] [Choose the Plan you'd like:]
[**Preferred**]
[☐ Member Only @ $xx,xx per pay period
☐ Member/spouse* @ $xx,xx per pay period
☐ Member/child @ $xx,xx per pay period
☐ Family @ $xx,xx per pay period]

[**Basic**]
[☐ Member Only @ $xx,xx per pay period
☐ Member/spouse* @ $xx,xx per pay period
☐ Member/child @ $xx,xx per pay period
☐ Family @ $xx,xx per pay period]

[Write Spouse/Domestic Partner/Partner to a Civil Union's* name below if you are applying for Member & Spouse or Member and Family coverage; if no Spouse/Domestic Partner/Partner to a Civil Union, or such person is not to be covered, put "N/A" or "None" in space below.

[Spouse/Domestic Partner/Partner to a Civil Union's Name:

_____]
First Middle Last

[2.] [Complete the following for the Applicant/Member, Spouse and child(ren)**for whom coverage is requested.

Insured	**Name**	**Date of Birth (MM/DD/YR)**
[Member]		
[Spouse]		
Child		
Child		
Child		

]

[3.] [Additional Information:
Membership Status: ☐Active ☐Retiree ☐Associate ☐Transitional]

[4.] [Billing Options- Please check one:
Checking Account: Account # _____Routing # : _____
Credit Card: Type_____Account #_____ Exp Date.: _____
Pension Deduction
Payroll Deduction (Available in locales that made necessary arrangements for this option)
Semi-Annual Direct Bill
Other Account Deduction: Type_____Account No._____
Expiration Date. : _____]

[5.] [Bill Me:
Monthly ☐ Semi-Annually
Quarterly ☐ Annually]

[Questions?
1-800-229-0451
Call us Monday through Friday between 8:00 a.m. and 5:00 p.m. EST.
(T.D.D. 1-203-754-4410)]

[Beneficiary: (Please print full name and relationship): _____ The applicant will be the beneficiary for his or her Spouse and/or Dependent Children if dependent coverage is selected unless designated otherwise.]	

[*Wherever the term Spouse appears, it will include Domestic Partner and/or Partner to a Civil Union, depending on state law, throughout the application. Domestic Partners must complete a Domestic Partner Affidavit with this application.]

[**Dependent Child must be unmarried, under age [19 - 25] ([23 - 29] if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Applicant for support and maintenance.]

[ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZE – UNDERSTAND]

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter: agree to the following: (a) All statements and Answers in this application are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (1) during the lifetime of all proposed insureds; and (2) while there is no change in the insurability and health of such person from that stated in the application (c) No agent has authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. [AUTHORIZE: (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, [Medical Information Bureau("MIB")], or any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, than any source has taken in reliance upon this authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for-insurance policy, and (3) the duration of a claim for benefits.] ACKNOWLEDGE receipt of the following notices: [(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes]; [(b) MIB Pre-Notice;] [(c) Investigative Consumer Report;] and (d) Outline of Coverage, if applicable. UNDERSTAND that" (a) I am applying for a [critical illness policy] and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable

[PRIMARY PROPOSED INSURED – If an investigative consumer report is prepared in connection with this Application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.]

[SPOUSE– If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.]

[Important Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

_____ _____
Applicant's Signature Date

[_____ _____
Applicant's Spouse's Signature Date
(if Spouse coverage is elected)]

[The following Notices must be detached and retained by the applicant.

NOTICE OF INFORMATION PRACTICES

The Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes.)

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. The Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 0112, telephone number 866 692 6901 [TTY 866 346 3642]. The Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
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Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125783910*	*State:*	*Arkansas*
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Product Name:	*Group Critical Illness / Cancer*		
Project Name/Number:	*Application for Group Livestrong Cancer Insurance Plan/GCI50014-AR-0808*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 08/24/2008

Comments:

Attachments:

AR Guaranty Notice.pdf

AR LH215AR_112805.pdf

Flesch Score Certif_45.9_. _MW_.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 08/24/2008

Comments:

Attachment:

AR Final Livestrong APP 8-08.pdf

Satisfied -Name: NAic Transmittal **Review Status:** Approved-Closed 08/24/2008

Comments:

Attachment:

NAIC Transmittal _3-07_ AIG .pdf

Satisfied -Name: Explanation of Variability **Review Status:** Approved-Closed 08/24/2008

Comments:

Attachment:

AR Final EOV 8-08.pdf

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or accident and health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

ARKANSAS
INSURANCE
DEPARTMENT
1200 West Third Street
Little Rock Arkansas 72201-1904
501-371-2600

Mike Pickens
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: AIG Life Insurance Company
Company NAIC Code: **0012-66842**
Company Contact Person & Telephone # **Maggie Sheehan 732-922-7688 or 800-548-4672**
Form Number(s): **GCI50014-AR-0808**

****
* INSURANCE DEPARTMENT USE ONLY *
* *
* ANALYST: _____ AMOUNT:_____ ROUTE SLIP:_____ *
****

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.		*	x $50 =
		**Retaliatory	
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.		*	x $50 =
		**Retaliatory	
Life and/or Disability Policy, Contract or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	Application	*1	x $20 = $20
		**Retaliatory	50.00
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms.		*	x $20 =
		**Retaliatory	
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.		*	x $25 =
		**Retaliatory	

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.	*	x $400 =	
Filing to amend Certificate of Authority.	***	x $100 =	

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE
AND REGULATION 57.

**THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK.
CODE ANN. 23-63-102, RETALIATORY TAX.

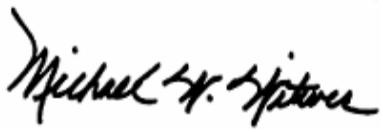
***THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. 23-61-401.

READABILITY CERTIFICATION

I, Michael Witwer, Senior Vice President Product Development, Marketing & Advertising of AIG Life Insurance Company, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Score is as follows:

Application For Group Livestrong Cancer Insurance Plan GCI50014-AR-0808 45.9.



Date: 8/20/2008

Michael Witwer
Senior Vice President
Product Development,
Marketing & Advertising

[AIG AMERICAN GENERAL] [Association/Entity Logo] [**Instructions**]

APPLICATION FOR GROUP [LIVE**STRONG**™ CANCER INSURANCE PLAN] [LIVE**STRONG**™ CANCER PLAN] [LIVE**STRONG**™ CANCER INSURANCE] [LIVE**STRONG**™ CANCER RECOVERY PLAN]

Underwritten by [AIG Life Insurance Company]
(Herein called the Company)
A member company of American International Group, Inc.
[Administrative Office: 3600 Route 66, Medical Underwriting 3-L, P.O. Box 1588 Neptune, NJ 07754-1588]

[Sponsoring Association Name]

[Member/Applicant] Name:
_____]
First Middle Last

[Address: _____
Street
_____]
City State Zip

Please provide the following personal information:

[Sex: Male: ☐ Female: ☐]
[Date of Birth_____]
[Social Security No: _____]
[Phone No: (___)_____]
[E-mail address:_____]

[The below section *only* to be completed by Preferred Plan Applicants. *Members applying for the Basic Plan do NOT need to answer these questions. The Basic Plan is offered on a guaranteed-issue basis. The Preferred Plan is offered on a simplified-issue basis and requires that you answer two health questions. Your approval for coverage will be based on your answers. If you do not qualify for the Preferred Plan, you will not be able to enroll in the guaranteed-issue Basic Plan.*]

[Please answer these brief questions.

[Member] [Spouse]

[1.] In the past [10 years] has any Proposed Insured been diagnosed with or received treatment or advice from a Medical Professional for cancer (including skin cancer and melanoma), leukemia, Hodgkin's disease, lymphoma, pre-malignant lesions or any immune deficiency disorder? ☐ Yes ☐ No ☐ Yes ☐ No

[2. Option 1] Within the past [12 months] has any Proposed Insured been advised by a Medical Professional to have any examinations, surgery or other medical tests to confirm, exclude or screen for the presence of cancer, or had test results which were abnormal or still pending? ☐ Yes ☐ No ☐ Yes ☐ No

[2. Option 2] Within the past [12 months] has any Proposed Insured had any abnormal test results for cancer? ☐ Yes ☐ No ☐ Yes ☐ No]

[I attest that no proposed insureds have been diagnosed or treated by any member of the medical profession for cancer (including skin cancer and melanoma), leukemia, Hodgkin's disease, lymphoma, pre-malignant lesions or any immune deficiency disorder, nor have any proposed insureds been advised by a Medical Professional to have any examinations, surgery or other medical tests to confirm, exclude or screen for the presence of cancer, or had test results which were abnormal or still pending.

_____
Signature of Primary Applicant]

[1.] [Choose the Plan you'd like:]
[**Preferred**]
[☐ Member Only @ $xx,xx per pay period
☐ Member/spouse* @ $xx,xx per pay period
☐ Member/child @ $xx,xx per pay period
☐ Family @ $xx,xx per pay period]

[**Basic**]
[☐ Member Only @ $xx,xx per pay period
☐ Member/spouse* @ $xx,xx per pay period
☐ Member/child @ $xx,xx per pay period
☐ Family @ $xx,xx per pay period]

[Write Spouse/Domestic Partner/Partner to a Civil Union's* name below if you are applying for Member & Spouse or Member and Family coverage; if no Spouse/Domestic Partner/Partner to a Civil Union, or such person is not to be covered, put "N/A" or "None" in space below.

[Spouse/Domestic Partner/Partner to a Civil Union's Name:

_____]
First Middle Last

[2.] [Complete the following for the Applicant/Member, Spouse and child(ren)**for whom coverage is requested.

Insured	**Name**	**Date of Birth (MM/DD/YR)**
[Member]		
[Spouse]		
Child		
Child		
Child		

]

[3.] [Additional Information:
Membership Status: ☐Active ☐Retiree ☐Associate ☐Transitional]

[4.] [Billing Options- Please check one:
Checking Account: Account # _____Routing # : _____
Credit Card: Type_____Account #_____ Exp Date.: _____
Pension Deduction
Payroll Deduction (Available in locales that made necessary arrangements for this option)
Semi-Annual Direct Bill
Other Account Deduction: Type_____Account No._____
Expiration Date. : _____]

[5.] [Bill Me:
Monthly ☐ Semi-Annually
Quarterly ☐ Annually]

[Questions?
1-800-229-0451
Call us Monday through Friday between 8:00 a.m. and 5:00 p.m. EST.
(T.D.D. 1-203-754-4410)]

[Beneficiary: (Please print full name and relationship): _____ The applicant will be the beneficiary for his or her Spouse and/or Dependent Children if dependent coverage is selected unless designated otherwise.]	

[*Wherever the term Spouse appears, it will include Domestic Partner and/or Partner to a Civil Union, depending on state law, throughout the application. Domestic Partners must complete a Domestic Partner Affidavit with this application.]

[**Dependent Child must be unmarried, under age [19 - 25] ([23 - 29] if attending an accredited institution of higher learning on a full time basis) and primarily dependent on the Applicant for support and maintenance.]

[ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZE – UNDERSTAND]

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter: agree to the following: (a) All statements and Answers in this application are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (1) during the lifetime of all proposed insureds; and (2) while there is no change in the insurability and health of such person from that stated in the application (c) No agent has authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. [AUTHORIZE: (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, [Medical Information Bureau("MIB")], or any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, than any source has taken in reliance upon this authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for-insurance policy, and (3) the duration of a claim for benefits.] ACKNOWLEDGE receipt of the following notices: [(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes]; [(b) MIB Pre-Notice;] [(c) Investigative Consumer Report;] and (d) Outline of Coverage, if applicable. UNDERSTAND that" (a) I am applying for a [critical illness policy] and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable

[PRIMARY PROPOSED INSURED – If an investigative consumer report is prepared in connection with this Application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.]

[SPOUSE– If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.]

[Important Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

_____ _____
Applicant's Signature Date

[_____ _____
Applicant's Spouse's Signature Date
(if Spouse coverage is elected)]

[The following Notices must be detached and retained by the applicant.

NOTICE OF INFORMATION PRACTICES

The Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes.)

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. The Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 0112, telephone number 866 692 6901 [TTY 866 346 3642]. The Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.]

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	AIG Life Insurance Company 3600 Rt. 66, Neptune, NJ 07753	Delaware	Group	0012	66842	25-1118523	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Maggie Sheehan 3600 Rt. 66, Neptune, NJ 07753	(732) 922-7688 (800) 548-4672	(732) 922-5593	Maggie_sheehan@aigag.com

5.	Requested Filing Mode	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	GCI50014-AR-0808
7.	☒ New Submission ☐ Resubmission	Previous file # _____
8.	Market	☐ Individual ☐ Franchise Group: ☐ Small ☐ Large ☒ Small and Large ☒ Employer ☒ Association ☐ Blanket ☐ Discretionary ☐ Trust ☒ Other: Statutory eligible groups
9.	Type of Insurance	H07G Group Health – Specified Disease – Limited Benefits
10.	Product Coding Matrix Filing Code	H07G.001 Critical Illness
11.	Submitted Documents	☒ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☒ Statement of Variability ☒ Certifications ☐ Actuarial Memorandum ☐ Other_____

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12.	**Filing Submission Date**	**August 20, 2008**			
13	**Filing Fee (If required)**	Amount	$50.00	Check Date	
		Retaliatory	☒ Yes ☐ No	Check Number	
14.	**Date of Domiciliary Approval**	April 4, 2008			
15.	**Filing Description:**				

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AIG Life Insurance Company wishes to submit the above referenced filing for your review and approval. This application replaces the individual application GCI50014-AR-0208, which was previously filed and approved by your Department on March 18, 2008. This application will be used with the Group Critical Illness Insurance product previously approved by your Department.

Our underwriting and marketing department has decided to make a few changes to the previously approved application (GCI50014-AR-0208). We have added a disclaimer just prior to the health questions, this disclaimer will be included as shown or omitted depending on plan design. Also, we have bracketed the title of the **ACKNOWLEDGEMENT-AGREEMENT-AUTHORIZE-UNDERSTAND** section, and the entire **Authorize** provision. We would like the flexibility to change the title to remove the word "Authorize" and will remove the entire Authorize section for certain plan designs with the understanding that if removed AIG will not be authorized to obtain the referenced reports.

Lastly, our underwriting department has decided on a more liberal underwriting approach with respect to the health questions and therefore has decided to have 2 versions of question #2 and we will use the version that is best matched up with plan design and marketing method. Question 2 – either the option 1 or option 2 question will be used depending on plan design and marketing method. Only one of these options will be used at a time. The look back period may range from 12 – 36 months but will never exceed the amount allowed by the state.

There are no other changes from the previously approved form.

Any bracketed information is being filed as variable and is illustrative. An Explanation of Variability (EOV) is included. Unless otherwise informed, we reserve the right on a case by case basis to alter the layout of the enclosed form, including color, type face and font, and to go outside the range of variables set forth in the application if we are requested to do so by the policyholder, but will only do so if such changes are within the allowable parameters or requirements in the state statutes.

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed. For example, the logo at the top of the application will be the logo of the association or company utilizing the application, who will then determine the address of the administrative office.

The flesch score for this form is enclosed.

To comply with the retaliatory fee requirement, included is a check in the amount of $50.00.

This application will be implemented for use upon approval by your Department.

Your review of this filing is appreciated. Please contact me if you have any questions.

Sincerely,
Maggie Sheehan
Analyst, Product Management
Maggie_sheehan@aigag.com
(732) 922-768; (800) 548-4672
FAX: (732) 922-5593

Enclosures

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16.	Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas

Print Name Maggie Sheehan Title Analyst

Signature

Maggie Sheehan

Date: **8/20/2008**

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17.	Form Filing Attachment
This filing transmittal is part of company tracking number	GCI50014-AR-0808
This filing corresponds to rate filing company tracking number	N/A

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	Application For Group Livestrong Cancer Insurance Plan Application	GCI50014-AR-0808	☐ Initial ☒ Revised ☐ Other _____	GCI50014-AR-0208 AMGN-125549695
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

LH FFA-1

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APPLICATION FOR GROUP [LIVE**STRONG™** CANCER INSURANCE PLAN] [LIVE**STRONG™** CANCER PLAN] [LIVE**STRONG™** CANCER INSURANCE] [LIVE**STRONG™** CANCER RECOVERY PLAN]

Explanation of Variability for Form No. GCI50014-AR-0808

GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case. Variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. The appropriate required language will always appear, but the arrangement or formatting may vary. Since the use of the enrollment may vary from electronic, to face-to-face, to direct mail, to telemarketing, etc… we need flexibility to conform the layout of the items found in the application to the layout in the marketing materials, etc… We certify that the type size will always remain as the State required size and all statutory/regulatory provisions and requirements will not be changed.

- Brackets around numbers or alphas in a listing and punctuation or words such as, “and”/”or” in a listing will be included or deleted as needed in order to make the statement read correctly. Numeric variables within the application will reflect the policy provisions and will always comply with the minimum statutory requirements of the jurisdiction in which the group policy is issued.

- The format may vary; however, the relative prominence of the provisions will not change.

- The Association, Administrator or Plan Logo, if inserted, will vary on a case-by-case basis.

Please note: The above variables will not be explained everywhere they appear. Items which are considered illustrative are not explained.

SECTION	EXPLANATION OF VARIABLE AREA
Heading	The reference to the name of the program may vary. In addition, in certain instances the program name may be omitted. The reference to the name of the insurance coverage may vary. In certain instances, at the client’s option it may be referred to as Cancer Expense Insurance or Cancer Insurance Plan, etc… The type of insurance is also bracketed as this application may also be used for Critical Illness coverage.
Logo	A space has been left for Association, Administrator or Plan logos to be included if a particular client requests it. Formatting of this information and some content may also vary depending upon group and solicitation method. Company Logo - This information will be included as shown or omitted

APPLICATION FOR GROUP [LIVE**STRONG™** CANCER INSURANCE PLAN] [LIVE**STRONG™** CANCER PLAN] [LIVE**STRONG™** CANCER INSURANCE] [LIVE**STRONG™** CANCER RECOVERY PLAN]

Explanation of Variability for Form No. GCI50014-AR-0808

Association Name	A space has been left for the Association name to be included if a particular client requests it.
Instructions	A space has been left for instructions for any client who wishes to include any type of instructional information regarding the completion of the form.
Member Name and address	The member information (name and address) will appear as shown or may be prefilled as part of the solicitation. Formatting of this information and some content may also vary depending upon group and solicitation method.
Personal Information Section	Any of the items may be included as shown or omitted. Formatting of this information and some content may also vary depending upon group and solicitation method.
Health Questions	The disclaimer before the Health Questions will be included as shown or omitted depending on plan design. Questions 1 and 2 will be included as shown or omitted. One or both of the questions may be omitted. Question 1 – the look back period may range from 3 – 10 years but will never exceed the amount allowed by the state. Question 2 – either the option 1 or option 2 question will be used depending on plan design and marketing method. Only one of these options will be used at a time. The look back period may range from 12 – 36 months but will never exceed the amount allowed by the state. Entire section for health questions will be included or may be omitted and replaced with the attestation statement in instances where we will require a health attestation rather than a response to specific health questions. (The attestation statement will only appear when the health questions are omitted, and when there are no health questions there will be no attestation statement.)
Plan Options	The plans listed will be included as shown or one or more of the plans available may be omitted. In certain instances, at the request of a client an additional plan option(s) may be added to allow for different benefits and to allow multiple plan choices.

APPLICATION FOR GROUP [LIVE**STRONG™** CANCER INSURANCE PLAN] [LIVE**STRONG™** CANCER PLAN] [LIVE**STRONG™** CANCER INSURANCE] [LIVE**STRONG™** CANCER RECOVERY PLAN]

Explanation of Variability for Form No. GCI50014-AR-0808

Plan Options (Cont.)	Rates may vary but these amounts will never exceed the state approved rates for this program. Marketing names for plans may be modified or omitted based on specific client needs (Example: Preferred and Basic might be changed to Bronze and Gold; or A and B etc.) Other descriptive information regarding plan options may be included as shown or omitted.
Dependent Info	This section may be included as shown or omitted. Formatting of this information and some content may also vary depending upon client needs.
Membership Status	This section may be included as shown or omitted. Formatting of this information and some content may also vary depending upon client needs.
Billing Options	The options listed will be included as shown or one or more of the options available may be omitted.
Beneficiary	This information will be included as shown or omitted.
Questions	This section may appear as shown or be omitted. Formatting of this information and some content may also vary depending upon client. The phone numbers will vary based upon group contact information
Billing Modes	The billing mode options listed will be included as shown or one or more of the options available may be omitted. Formatting and content of this information may vary depending on billing option selected.
Dependent Eligibility	The dependent ages may vary but will never be less than those mandated by the state.
Acknowledgement-Agreement-Authorize-Understand	The title of this section may be changed to remove the Authorization section for certain plan designs.

APPLICATION FOR GROUP [LIVE**STRONG™** CANCER INSURANCE PLAN] [LIVE**STRONG™** CANCER PLAN] [LIVE**STRONG™** CANCER INSURANCE] [LIVE**STRONG™** CANCER RECOVERY PLAN]

Explanation of Variability for Form No. GCI50014-AR-0808

Acknowledgement-Agreement-Authorize-Understand (Cont.)	The Authorization section may be included as shown or omitted for certain plan designs.
Important Notice	The language will be included as shown, or may be replaced with the appropriate state specific language.
MIB Disclosure	This disclosure will always be provided to the customer, when applicable. It may appear as an attachment beneath the application, as a separate notice with the application or as an attachment in a brochure. For this reason, the language related to the notice being retained by the applicant may vary based upon the manner in which it is provided. This is also being bracketed as variable as it may be omitted in instances where no MIB is required.